United States Court of Appeals

for the

District of Columbia Circuit

TRANSCRIPT OF RECORD

BRIEF FOR APPELLANT

IN THE UNITED STATES COURT OF APPEALS

FOR THE DISTRICT OF COLUMBIA CIRCUIT

NO. 20366

MELVIN W. ALEXANDER, patient, Appellant

v.

DALE C. CAMERON, Superintendent of
SAINT ELIZABETH'S HOSPITAL, Appellee

APPEAL FROM THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF COLUMBIA

William R. Stratton
1000 Vermont Avenue., N.W.
Washington, D.C. - 20005

September 14, 1966

STATEMENT OF QUESTIONS PRESENTED

1. May an individual shown to be mentally defective but not otherwise suffering from any recognized psychosis or mental disease be civilly committed under the District of Columbia Hospitalization Mentally Ill Act?

2. May an individual whose criminally sanctionable conduct has brought him before the United States District Court be civilly committed under the District of Columbia Hospitalization of the Mentally Ill Act in the absence of a showing that he will receive treatment while so committed?

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JURISDICTIONAL STATEMENT

In the United States District Court for the District of Columbia this was a proceeding for the judicial hospitalization of an individual under Title IV of the District of Columbia Hospitalization of the Mentally Ill Act, Public Law 88-597, 78 Stat. 944 (1964), codified by Public Law 89-193, 79 Stat. 751 (1965) at Chapter 5, Title 21, District of Columbia Code. Provisions of the statute reposing jurisdiction in the United States District Court for the District of Columbia are to be found at Sections 21-501 and 21-545 D.C. Code, 1961 Edition (Supp. V, 1966).

Jurisdiction in this Court is founded upon the Act of June 25, 1948, 62 Stat. 929,930, 28 United States Code 1291, 1294.

STATEMENT OF THE CASE

On December 4, 1965, an officer of the Metropolitan Police Department received a radio report that a man had exposed himself to a young girl at the rear of 3207 11th Place, Southeast. Responding to the call, the officer encountered the appellant, MELVIN W. ALEXANDER. After investigating the circumstances the officer transported Mr. Alexander to Saint Elizabeth's Hospital and applied for his emergency hospitalization.

Mr. Alexander's hospitalization under the statutory provisions allowing hospitalization of the allegedly mentally ill for emergency and diagnostic purposes continued until December 13, 1965.

On that date, appellee, Superintendent of Saint Elizabeth's Hospital, petitioned the United States District Court for the District of Columbia (hereafter District Court) to order Mr. Alexander's judicial hospitalization. This petition was supported by an affidavit of a staff physician at Saint Elizabeth's Hospital stating that Mr. Alexander was suffering from Mental Deficiency, Idiopathic, Moderate and was likely to injure himself or others if allowed to go at liberty. The District Court, on December 13, 1965, ordered Mr. Alexander's continued hospitalization until a final order of commitment or release was entered.

The matter was then referred to the Mental Health Commission. On January 11, 1966 the Commission found Mr. Alexander to be suffering from mental deficiency, and because of that mental condition (termed an illness by the Commission) likely to injure himself or others if allowed to remain at liberty. The Commission recommended to the District Court that Mr. Alexander be hospitalized indefinitely at Saint Elizabeth's Hospital.

Mr. Alexander demanded a jury trial on the issue of his mental illness and the likelihood of his injuring himself or others if at liberty. The trial was had on February 9, 1966. Psychiatric expert witnesses produced by the government on the trial were two, the staff physician from Saint Elizabeths Hospital whose affidavit accompanied the petition for judicial hospitalization, and a physician -member of the Mental Health Commission. The staff physician testified that Mr. Alexander had a mental defect (Tr. 19) which she diagnosed as mental deficiency, ideopathic, moderate (Tr. 23) (Tr. 25) and that he suffered from no psychoses or neuroses (Tr. 25, 26). The Mental Health Commission doctor testified that Mr. Alexander had a mental defect characterized by mental deficiency (Tr. 40), that he concurred with the hospital staff diagnosis of mental deficiency, ideopathic, moderate (Tr. 45), that the patient suffered no psychosis (Tr. 45); this expert's opinion was that the patient should be hospitalized for a mental disease or defect (Tr. 48); Mental defect was equated with mental disease in the doctor's testimony (Tr. 49).

Appellant's counsel requested the District Court to instruct the jury that mental defect was not a mental illness within the meaning of the governing statute. (Tr. 60); the request was denied (Tr. 61) (Tr. 62). A requested instruction that the jury not be permitted to return a verdict that would lead to involuntary hospitalization unless they found

that treatment would follow was also not granted (Tr. 65). The District Court instructed the jury that they could consider a mental defect to be a mental illness within the meaning of the statute (Tr. 80). The jury's verdict was that Melvin Alexander was mentally ill and likely to injure himself or others if allowed to go at liberty. This verdict was confirmed by the Court on February 9, 1966 and on February 10, 1966 Mr. Alexander was hospitalized at Saint Elizabeths Hospital pursuant to a final order of the District Court dated that day. It is that final order from which this appeal is taken.

STATUTES INVOLVED

Title 21, Section 501, District of Columbia Code, provides:

> "Definitions.
>
> As used in this chapter:
>
> .....
>
> 'mental illness' means a psychosis or other disease which substantially impairs the mental health of a person.
>
> . . . . . .
>
> 'mentally ill person' means a person who has a mental illness....."

Title 21, Section 545(b), District of Columbia Code, provides:

> "(b) If the Court or jury, as the case may be, finds that the person is not mentally ill, the Court shall dismiss the petition and order his release. If the Court or jury finds that the person is mentally ill and, becuase of that illness, is likely to injure himself or other persons if allowed to remain at liberty, the Court may order his hospitalization for an indeterminate period, or order any other alternative course of treatment which the Court believes will be in the best interests of the person or the public.."

Title 21, Section 562, District of Columbia Code, provides:

> " A person hospitalized in a public hospital for a mental illness shall, during his hospitalization, be entitled to medical and psychiatric care and treatment."

SUMMARY OF POINTS

1. The District Court erred in instructing the jury over appellants' objection that it could consider a mental defect to be a mental illness within the meaning of the statute, and in ordering hospitalization upon the jury's verdict.

2. The District Court erred in ordering appellant's hospitalization in Saint Elizabeths Hospital in the absence of a showing that he would receive medical and psychiatric treatment there.

SUMMARY OF ARGUMENT

I. Mental deficiency standing alone is not a mental illness for which an individual may be judicially hospitalized under the controlling statute in the Dis-rict of Columbia. The government must show in a proceeding for the judicial hospitalization of a mental defective that he suffers from a mental illness in addition to mental defectency. No such showing was made in this case, therefor the petition should have been dismissed.

II. The controlling statute requires that persons involuntarily hospitalized in a public hospital for mental illness receive treatment for their illness. The evidence showed that appellant would receive only custodial care: it was, therefor, error to commit him to a public hospital.

ARGUMENT

I.A. Mental deficiency is not a mental illness for which a person may be involuntarily hospitalized under the District of Columbia Hospitalization of the Mentally Ill Act.

The District of Columbia Hospitalization of the Mentally Ill Act (hereafter the "Act") public law 88-597, 78 Stat. 944 (1964), revised and codified, public law 89-183, 79 Stat. 751 (1965), 21 D.C. Code 1961 Ed. 501 et. seq (Supp. V, 1966) was the legislative product of an exhaustive Congreeional inquiry into the constitutional rights of the mentally ill generally and the procedures respecting civil commitments in the District of Columbia particularly.

S. 935, 88th Congress, 1st Session is the bill which became the Act. As the bill was introduced, the section setting out the mental condition which would render an individual liable to involuntary judicial hospitalization read as follows:

> " (1) the term 'mental illness' means any psychosis or other disease which substantially impairs the mental health of an individual (but shall not include epilepsy, alcoholism, drug addiction, or mental deficiency);"

109 Congressional Record 3110, 3114 (February 28, 1963).

Hearings on this bill were held on May 2, 3 and 8, 1963 before the Subcommittee on Constitutional Rights of the Senate Committee on the Judiciary. The statements of many of the organizations and individuals invited to testify dealt with the foregoing definition.

Dr. Jack R. Ewalt, president of the American Psychiatric Association, on behalf of that Association stated:"The specific exclusion of epilepsy, alcoholism, drug addiction, and mental deficiency from the definition of mental illness does not seem useful, for the simple reason that persons suffering such disorders may and often do have mental illness as well. Mentally ill persons should not be excluded from needed hospitalization by virtue of the presence of one or more symptoms." Hearings p. 75.

The position statement of the Washington Psychiatric Society, submitted by Sidney Berman, M.D. read as follows: " 1. In section 2 under 'Definitions' it is felt that the terms as defined need further clarification in order to conform to current medical practice, so that the legal and medical terminology is in harmony. It is correct that epilepsy, mental deficiency, alcoholism and drug addiction are symptoms which may be associated with various types of mental illness. It was felt that this part of the bill or line 1,

page 2, section 2(A), contained in the parentheses could be deleted. The structure of the bill is such that hospitalization could not be exploited by the individuals with these conditions. Futhermore, since psychoses may occur with these conditions, the physician should be free to recommend hospitalization without being hampered by this restriction." Hearings p.77.

The comments of the Committee on Mental Health appointed by the Commissioners of the District of Columbia were delivered by Commissioner Duncan. He stated, "In section 2 of the bill, the definition of 'mental illness'includes a provision to the effect that such term ' shall not include epilepsy, alcoholism, drug addiction, or mental deficiency.' The Commissioners' Committee is of the view that these specific exclusions are undesirable, since convulsive disorders, alcoholism, and drug addiction may be symptoms of mental illness." Hearings p. 82. This report, by a blue ribbon committee, went on to say: "Mental retardation per se is distinct from mental illness and may appropriately be excluded from the definition. However, the mentally retarded with substantial mental illness in addition to their retardation should not be excluded." Hearings p.87.

Again, the Superintendent of Saint Elizabeths Hospital appellee herein, in testifying on the bill stated, " we

suggest that the phase ' epilepsy, alcoholism, drug addiction, or mental deficiency' which are exclusions from the definition of mental illness in the proposed bill, be deleted. Epilepsy and mental deficiency are not mental illnesses per se and, therefore, excluding them is somewhat redundant. Many alcholics and drug addicts may have these conditions simply as a symptom of their mental disorder, and to exclude a person because he happens to have one or another symptom would seems(sic) to us to be inappropriate." Hearings pp. 128, 133.

Thus, every expert medical consideration of the bill recommended change of the definition to exclude the words in parentheses. This was not because epilepsy, drug addiction, alcoholism and mental deficiency are considered to be mental illnesses by the medical fraternity, and that persons with those conditions should be subject to the bill. To the contrary, as the Commissioners' Committee on Mental Health Needs and the staff of Saint Elizabeths Hospital stated, mental deficiency is not a mental illness. Rather, the reason to modify the definition announced by the medical experts was that, in their reading of the bill, hospitalization could be denied an alcoholic or drug addict whose addiction was a symptom of a mental illness or to an epileptic or mentally retarded person who had a co-existent mental illness.

Whether the medical experts read the bill correctly or incorrectly in arriving at the basis for their recommendations is an open question. The fact is, the Senate Committee on the Judiciary responded to their reasoning. In reporting the bill, Senate Report 925, 88th Congress, 2d Session, the definition of mental illness was amended by deletion of the words in parentheses in the original, i.e. "(but shall not include epilepsy,alcoholism, drug addiction, or mental deficiency);". The announced reason for the Committee amendment was that of its witnesses: " This section differs from the original bill which had excluded epilepsy, alcoholism, drug addiction, or mental deficiency from the definition of 'mental illness.' Witnesses testified that these symptoms often accompany mental illness and that persons who are mentally ill and have one or more of these conditions should not be excluded because of such a condition." S Rept. 925, 88th Congr., 2d. Sess., p. 13.

In the House of Representives hearing's were held on the bill (August 10, 1964) and it was reported (House Report 1833, 88th Congress, 2d Sess.) with the identical comment on the definition of mental illness (ibid. p. 13) and passed (110 Congr. Rec. 20787) as reported.

Appellant submits that only one conclusion can be drawn from the legislative history of the Act. Namely, that the

Congress accepted the advice of its expert witnesses that mental deficiency is not itself a mental illness, but that mental illness can coexist with mental deficiency; and, therefore, the Act should be unambiguous on the point that a person both mentally deficient and mentally ill could be hospitalized involuntarily. The obverse of the coin was equally clearly struck - a person who is mentally deficient but not mentally ill may not be hospitalized involuntarily under this statutory authority.

In the case on appeal the medical testimony, on the reading most favorable to appellee, showed that appellant was mentally deficient with abnormal behavioral reactions. These behavioral reactions were never identified as a disease entity. The jury was instructed that mental deficiency was a mental illness within the meaning of the Act. This was a clear error of law requiring reversal and dismissal of the petition for appellants' judicial hospitalization.

B. Considering the District of Columbia Hospitalization of the Mentally Ill Act in the context of the statutory scheme of which it is an element reveals the validity of the first proposition of this argument.

The Congress was not writing on a clean slate when it enacted the Hospitalization of the Mentally Ill Act -

particularly as regards persons who are merely retarded mentally.

The District of Columbia is far from unique in recognizing the difference and disparity between mental deficiency and mental illness and according treatment of these differing conditions in different, specialized facilities.* Public law 89-183, 79 Stat. 766 (1965), in codifying the several enactments dealing with the legally disabled, collected the statutes governing commitments and care of the mentally retarded or feeble minded. These statutes appear at Chapter 11 of Title 21 of the District of Columbia Code, 1961 Ed. (Supp. V, 1966).

* For a tabulation of the differing staturory definitions and provisions relating to mental illness and mental deficiency see Table II -a (p. 44 et seq.) and Table II -i (p. 76 et seq.) of The Mentally Disabled and the Law, 1961, a report of the American Bar Foundation on the Rights of the Mentally Ill, Frank T. Lindman and Donald M. McIntyre, Jr., there, at 21 D.C. Code 1101, a feeble-minded person is defined as one "..... afflected with mental defectiveness from birth or from an early age, so pronounced that he is incapable of managing himself or his affairs, or being taught to do so, and who requires supervision, control and care for his own welfare, or for the welfare of the community, and is not mentally ill to such an extent as to require his commitment to Saint Elizabeths Hospital, as provided by Chapter 5 of this Title or other laws with respect to the commitment and custody of mentally ill persons." Feeble minded persons are commitable to the District of Columbia Training School 21-1108 D.C. Code, 1961 Ed., (Supp. V, 1966).

It is appellant's contention that the Act under which he has been committed must be considered in the light of the dual statutory scheme for treating the mentally defective seperately from the mentally ill. To do so, clearly indicates the desire of Congress that mentally defective persons be considered in a context apart from those who are mentally ill. Admittingly, a mental defective who suffers from a mental illness is commitable to Saint Elizabeths Hospital under the Hospitalization of the Mentally Ill Act. But clearly the burden of establishing the illness lies with the government, and, equally clearly, that burden was not sustained on the trial below. A basis textbook, MODERN CLINICAL PSYCHIATRY, Lawrence C. Kolb and Arthur P. Noyes (6th Ed., 1963) at p. 290 points out that, "Mental deficiency, then, is a symptom associated with a large number of disease entities which affect the organism in its earliest stages of growth and development. It is not a clinical entity in itself." In short, mental deficiency is not a mental illness. For there to be a commitment of a mental defective under the Act there must be evidence of the existence of such an illness independent of the mental retardation. No such evidence was adduced on the trial. Indeed the two differing mental conditions was not drawn for the jury; if anything it was blurred.

Appellant submits that his commitment did or could have resulted from the equation in the minds of the jury between mental defect and mental illness and is therefore, contrary to law.

II. The Hospitalization of the Mentally Ill Act requires medical care and treatment of a hospitalized patient; absent a showing that such care and treatment will be forthcoming in accordance with a reasonable standard involuntary hospitalization is contrary to law.

The Act is mandatory, " A person hospitalized in a public hospital for a mental illness shall, during his hospitalization be entitled to medical and psychiatric care and treatment." 21-562 D.C. Code, 1961 Ed., (Supp. V, 1966). On the trial the government offered no evidence of the medical or psychiatric care available to or in prospect for the patient if he were hospitalized. On cross examination the staff psychiatrist indicated that Saint Elizabeths could offer, "custodial care.. in a controlled environment." (Tr. 30). In short, the hospital would serve as a place of confinement. Appellant's testamony (Tr. 54-56) indicated he had no individual or group contact with hospital physicans. If care and treatment are not to be provided commitment is not authorized under the law.

CONCLUSION

For the foregoing reasons this matter should be remanded to the District Court with instructions to dismiss the petition.

Respectfully submitted,

W Thatton

294.

REPLY BRIEF FOR APPELLANT

IN THE UNITED STATES COURT OF APPEALS

FOR THE DISTRICT OF COLUMBIA CIRCUIT

NO. 20366

In Re: Melvin W. Alexander, patient, Appellant

Dale C. Cameron, Superintendent of

Saint Elizabeth's Hospital, Appellee

APPEAL FROM THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF COLUMBIA

William R. Stratton
1000 Vermont Avenue, N.W.
Washington, D.C. - 20005

Mental Health No. 25-66

November 17, 1966

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REPLY TO ARGUMENT OF APPELLEE

I. Appellant could not be other than fully in accord with the proposition that mental illness and mental deficiency may co-exist in one individual. Such an individual, if his mental illness is danger-productive, is commitable under the District of Columbia Hospitalization of the Mentally Ill Act <u>on account of his mental illness.</u>

Some mentally defective persons engage in anti-social or danger-productive behavior as do some persons of normal intellect. Such behavior by a mentally defective person may be an act of free will of the intellect, however stunted, or it may be the result of a mental illness that co-exists with his mental deficiency. If the latter, the individual is civilly commitable under the Act· if the former, he is not. Just as there must be a showing that danger-productive behavior by a person of normal intellect is the result of a mental illness in order to sustain a commitment under the Act, so must there be a showing that danger-productive behavior by a person of below normal intellect is the result of a mental illness in order to sustain his commitment. There is no presumption that danger -

productive behavior by a person of below normal intellect is the product of a mental illness, yet, to Appellant it appears that premise underlies Appellee's argument. No such presumption can be derived from the statute or its history. Thus, to sustain the civil commitment of a mentally defective person there must be evidence in the record that his danger-productive behavior was the result of a mental illness, which illness may exist independently or interdependently with the mental deficiency.

If, in every case of danger-productive behavior by a mental defective, the jury were instructed that mental deficiency is evidence of mental illness the distinction between illness and deficiency would be lost. Rather, the proposition should be formulated if evidence exists in the record of danger-productive mental illness arising out of mental deficiency then the jury may consider the mental deficiency as evidence of mental illness. In short, unless medical or legistative support can be found for the proposition that all mental defectives are mentally ill, it is improper to instruct a jury that mental deficiency is evidence of mental illness. Appellant believes that the general proposition is in-supportable; therefore, there must be evidence in the individual record of a mentally illness causally related

to the mental deficiency to justify the instruction that the deficiency is evidence of the illness.

II. Appellant could subscribe to Appellee's second argument if it were stated thus: Commitment is justified under the Act by the existence in a mental defective of a danger-productive mental illness which is related to the mental deficiency and of which the deficiency may be one component. If the deficiency is a component of the illness, proof of a co-existing mental illness independent of the deficiency is not required. In other words, if it is impossible to attribute danger-productive behavior in an individual who is both mentally deficient and mentally ill to either the deficiency or the illness because the danger-productive behavior is the result <u>of both</u> the deficiency and the illness commitment is justified. On the other hand, if the illness and the deficiency are not related or coalesced, commitment is justified only if the danger-productive behavior flows from the illness.

III. Appellant agrees that a reasonably expansive interpretation should be given to the statutory definition of mental illness, ".....a psychosis or other disease which substantially impairs the mental health of

a person". Certainly the fact that a mental condition does not fit one of the nomenclatural pigeon holes of the American Psychiatric Association's classification system would not prohibit the condition from falling under the Act's definition of mental illness. This is not to say, however, that the Hospitalization of the Mentally Ill Act was intended to obliterate the acknowledged distinction between mental illness and mental deficiency where it exists, to the contrary, the Congress has drawn that distinction rather than blurred it by providing a separate treatment facility and different commitment procedures for theementally ill, 21-1101 et seq., D.C. Code, 1961 ed. (Supp. V, 1966).

Danger-productive behavior by a mental defective, if criminally sanctionable, may result in involuntary commitment after proof of the confession of the crime by the individual and a finding of not guilty by reason of insanity, whether or not the individual is mentally ill as well as mentally defective and whether or not the mental defect is a component of the mental illness. In the criminal law the court-drawn, behavior-oriented, insanity definition which reaches the merely mentally de-

fective has reached full flower. It is perhaps well that this is so in the context of the rehabilitation effort directed at those found beyond a reasonable doubt to have committed a crime. There the choice is between jail and, at worse, custodial confinement. or, at best, salvation of a member of society. But, if it may be conceded that correction or "treatment" of mental deficiency is much less successful than treatment of mental illness, ought not civil commitment of the mentally deficient against their will be surrounded with some additional protections, especially under a "right to treatment" statute? Appellant suggests that the statute involved offers such protection to the mentally deficient in the requirement that there be a finding of co-existing mental illness productive of dangerous behavior.

Except for this, every retarded person who breached a convention or regulation of society through ignorance or niavete would be commitable, a result rather clearly not intended by the Congress. Therefore, there are limits on the expansiveness of the definition of mental illness which may be presented to a jury.

IV. If the Congress intended that mental deficiency without an independent or interdependent co-existing mental illness was not a mental condition rendering its

possessor subject to civil commitment, it was error for the Court to instruct the jury that a mental defect may be considered by you as a mental illness in the meaning of the statute. (Tr. 80) Appellee, really does not argue this point, except to say that it is not open to Appellant to raise it because at one point in the proceedings, (Tr. 62) Appellant's counsel asked the Court after his request to instruct the jury that mental deficiency was <u>not</u> a mental illness was denied to instruct to the contrary. Clearly, as the context shows (Tr. 60-63, Tr. 79) Counsel's purpose was to obtain a ruling and an instruction to the jury on the question.

V. The Hospitalization of the Mentally Ill Act provides that, "A person hospitalized in a public hospital for a mental illness shall, during his hospitalization, be entitled to medical and psychiatric care and treatment." Section 21-562 D.C. Code, 1961 Ed., (Supp. V., 1966). This provision of the statute clearly covers the person's entire hospitalization. If the patient is able to show, as appellant did, (Tr. 53-56) that in the two months or more he had been at the hospital he had had virtually no contact with the hospital's psychiatric staff. A showing of absence of treatment is made, and an inference arises

that treatment will not be forth coming in the future. It then becomes incumbert upon the Court, (if the jury finds a danger-productive mental illness) in ordering ".....hospitalization.....or any other alternative course of treatment which the Court believes will be in the best interests fo the person or the public " to examine the nature and quality of treatment available for the patient at Saint Elizabeth's Hospital, District of Columbia Training School, welfare agencies or foster homes. A patient with a demonstrated history of neglect by hospital authorities ought not have to return to the hospital to abide another six months of neglect while his right to test the violation of his right to treatment by habeas corpus matures.

Respectfully submitted

William R. Stratton

BRIEF FOR APPELLEE

United States Court of Appeals

FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 20,366

IN RE: MELVIN W. ALEXANDER, PATIENT

Appeal from the United States District Court for the District of Columbia

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DAVID G. BRESS,
United States Attorney.

FRANK Q. NEBEKER,
WILLIAM M. COHEN,
Assistant United States Attorneys.

ROBERT A. ACKERMAN,
Attorney, Department of Justice.

Mental Health No. 25-66

QUESTIONS PRESENTED

In the opinion of the appellee, the following questions are presented:

1) May mental deficiency be considered as evidence of mental illness for purposes of civil commitment under the District of Columbia Hospitalization of the Mentally Ill Act?

2) To justify commitment of a mental defective under the Hospitalization of the Mentally Ill Act must there be evidence of a mental illness independent of the subject's mental deficiency, or is commitment justified by the existence of a mental illness productive of dangerous behavior where the illness is related to the mental deficiency and of which the mental deficiency may be a component part?

3) In order to meet the broad legal definition of mental illness established by the Hospitalization of the Mentally Ill Act ("a psychosis or other disease which substantially impairs the mental health of a person"), must the mental illness which a person is found to have be precisely defined in psychiatric terms fitting one of the various categories of mental illness as currently recognized within the psychiatric discipline at its present stage of development?

4) Was it error for the trial judge to instruct the jury that a mental defect may be considered as a mental illness within the meaning of the Hospitalization of the Mentally Ill Act when appellant's counsel had previously requested an instruction that mental deficiency is a mental illness, when appellant's counsel did not object to the instruction as given, and when the judge also instructed that the jury must find whether the person would be a danger to himself or others if left in society and cautioned that many mental defectives get along perfectly well in society?

5) Must commitment of a person found mentally ill and otherwise committable under the Hospitalization of the Mentally Ill Act be preceded by a showing at trial that psychiatric treatment will be given to him during hospitalization?

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FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 20,366

IN RE: MELVIN W. ALEXANDER, PATIENT

Appeal from the United States District Court for the District of Columbia

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BRIEF FOR APPELLEE

COUNTERSTATEMENT OF THE CASE

Melvin W. Alexander is a twenty-five year old mental defective with an I.Q. of 49. He has a history of indecent exposure to little girls. He was sent to Laurel Children's Center in 1958 after one exposure incident and remained there until release in 1961. He was sent to Saint Elizabeths Hospital in 1962 after another exposure incident and remained there until released in April, 1965.

On December 4, 1965 a police officer responded to a call that a man had exposed himself to a female child in an alley. The officer found Mr. Alexander at the scene with his zipper open, investigated the circumstances, learned that Mr. Alexander had been in Saint Elizabeths, and transported him there for emergency hospitalization.

On December 13, 1965 the Superintendent of Saint Elizabeths petitioned the District Court to order Mr.

Alexander's judicial hospitalization under the District of Columbia Hospitalization of the Mentally Ill Act (hereinafter Act). The petition asserted that he had been hanging around the alley where he was taken into custody every lunch hour when the children were coming home from school and exposing himself (however, no evidence to this effect was introduced at trial). This petition was supported by an affidavit of a Saint Elizabeths staff psychiatrist stating that Mr. Alexander was "mentally ill, suffering from Mental Deficiency, Idiopathic, Moderate; and because of such illness is likely to injury himself or others if allowed to go at liberty" and that he was unable to control his actions or to understand their gravity or their consequences. The District Court ordered Mr. Alexander's continued hospitalization until a final order of commitment or release was entered. The matter was referred to the Mental Health Commission.

The Commission found Mr. Alexander to be "mentally ill suffering from Mental Deficiency, and because of such illness, is likely to injure himself or others if allowed to remain at liberty". The Commission recommended to the District Court that he be hospitalized indefinitely at Saint Elizabeths.

Mr. Alexander demanded a jury trial on the issues whether he was mentally ill or not and whether or not he was likely to injure himself or others if allowed to remain at liberty. At trial two psychiatrist expert witnesses who had examined him, one the staff physician from Saint Elizabeths whose affidavit supported the petition for commitment, and the other a physician member of the Mental Health Commission, each testified clearly that Mr. Alexander had a mental illness and that he might injure himself or others if he were not hospitalized. Each psychiatrist testified that he had a mental defect, but that his mental disability was not limited to this intellectual impairment. Each testified that Mr. Alexander had behavioral reactions in addition to the mental deficiency which were manifested in his exposing himself

(Tr. 28, 29, 40, 41, 47). This expert testimony that Mr. Alexander was mentally ill and should be hospitalized was uncontradicted.

Neither psychiatrist equated mental defect with mental disease. The testimony of the Mental Health Commission physician at Tr. 49 meant only that in this case Mr. Alexander is suffering from both a defect and a disease, as his testimony as a whole makes clear, and particularly so at Tr. 47.

Both psychiatrists testified that there was little hope that Mr. Alexander could function normally in society but that his disability could be treated with hope of improvement. The physician from Saint Elizabeths testified that the hospital could offer custodial care and a controlled environment including treatment, guidance, and therapy (Tr. 30). This physician testified that Mr. Alexander had apparently refrained from exposing himself during earlier periods of mental hospitalization (Tr. 30).

Judge Walsh instructed the jury that mental illness within the meaning of the Act meant any psychosis or other disease which substantially impairs the mental health of the individual. He instructed that mental deficiency could be considered as evidence of mental illness. Appellant's counsel requested an instruction that mental deficiency is a mental illness within the Act (Tr. 62). Appellee's counsel relied on appellant's request for and agreement to such an instruction in his statement to the jury (Tr. 68, 69, 72). Appellant's counsel then changed his position and indicated opposition to such a charge (Tr. 79). Judge Walsh instructed that the jury in this case could consider a mental defect as a mental illness. Appellant's counsel did not object to the charge as given. Judge Walsh further instructed that the jury had also to find whether the person would be a danger to himself or others if not hospitalized. He cautioned the jury clearly that many mental defectives get along perfectly well in society (Tr. 80).

Judge Walsh denied a request of appellant's counsel for an instruction that the jury should not return a verdict

that would lead to involuntary hospitalization if they found that he would not receive treatment in the hospital (Tr. 65).

The jury found that Mr. Alexander was mentally ill and would be a danger to himself or to society if he remained at large. He was hospitalized at Saint Elizabeths pursuant to a final order by Judge Walsh of February 10, 1966. From this order, based on the verdict of the jury under these instructions, appellant now appeals.

STATUTES INVOLVED

Title 21, Section 501, District of Columbia Code, provides in pertinent part:

> Definitions.
>
> As used in the chapter:
>
> . . . . . .
>
> "mental illness" means a psychosis or other disease which substantially impairs the mental health of a person;
>
> "mentally ill person" means a person who has a mental illness. . . .

Title 21, Section 545(b), District of Columbia Code, provides in pertinent part:

> (b) If the Court or jury, as the case may be, finds that the person is not mentally ill, the court shall dismiss the petition and order his release. If the court or jury finds that the person is mentally ill and, because of that illness, is likely to injury himself or other persons if allowed to remain at liberty, the court may order his hospitalization for an indeterminate period, or order any other alternative course of treatment which the court believes will be in the best interests of the person or the public. . .

Title 21, Section 562, District of Columbia Code, provides:

> Medical and psychiatric care and treatment; records.
>
> A person hospitalized in a public hospital for a mental illness shall, during his hospitalization, be entitled

to medical and psychiatric care and treatment. The administrator of each public hospital shall keep records detailing all medical and psychiatric care and treatment received by a person hospitalized for a mental illness and the records shall be made available, upon that person's written authorization, to his attorney or personal physician. The records shall be preserved by the administrator until the person has been discharged from the hospital.

SUMMARY OF ARGUMENT

Appellant requested a jury instruction that mental deficiency is a mental illness within the Act. Appellee in his closing statment to the jury relied on appellant's agreement to such an instruction. Appellant did not object to instructions given thereafter that mental deficiency may be considered as evidence of mental illness under the Act and that the jury in this case could consider a mental defect as a mental illness within the Act. Appellant cannot now attack a jury verdict based in part on these instructions, especially where the trial judge cautioned that many mental defectives are not dangerous and get along perfectly well in society and otherwise made it clear that mental illness and mental deficiency are not synonymous.

The clear intent of Congress was to allow mental defectives who also have a mental illness making it dangerous for them to remain in society to be committed under the Act. While there is usually no essential relationship between mental deficiency and mental illness, the two cannot always and necessarily be regarded as separable. It is sometimes very difficult for physicians to distinguish mental deficiency from some forms of mental illness. Even where mental deficiency is correctly diagnosed by physicians, the person may also be mentally ill. There are several factors which can contribute to the incidence of mental illness among mentally deficient persons. Occasionally the same factor which produced damage to the nervous system causing mental deficiency may also pro-

duce forms of mental illness. Evidence of mental deficiency is thus relevant in determining whether a person is mentally ill. Congress has recognized it as such.

Mental deficiency in a person, standing alone, does not justify his involuntary hospitalization under the Act as a mentally ill person. However, commitment is justified for a mentally deficient person who has a mental illness which is related to the mental deficiency and of which the deficiency may be a component. Proof of coexisting mental illness independent of the deficiency is not required. Thus Mr. Alexander's mental deficiency, taken together with his repeated and apparently compulsive behavior pattern of exposing himself to little children, which in combination is considered by psychiatrists to constitute a mental illness, is sufficient to constitute a mental illness for purposes of the Act and a jury may properly so find. The illness found to exist by the jury need not be labeled precisely by either psychiatrists or lawyers as falling within one of the established categories of mental illness currently recognized within the psychiatric discipline (paranoia, schizophrenia, sociopathic personality disturbance, etc.). Nothing in the Act requires such labeling. Experience in criminal law under the *Durham* and *McDonald* definitions of mental disease or defect is relevant as showing the lack of value of such labeling, the possible harm such labeling by psychiatric expert witnesses may do in eroding the jury's function, the value of distinguishing between judicial and psychiatric definitions of mental illness and mental defect, and the value of having psychiatrist witnesses describe and explain to the jury the behavior of defendants rather than merely label it in psychiatric terms. The psychiatric discipline may continue to develop as rapidly as it has in the past. Maintenance of the broad legal definition of mental illness established in the Act, as opposed to attempting to formulate judicial definitions of forms of mental illness more precise than the psychiatric definition for those forms currently used by the psychiatric discipline, will make it possible

to take advantage of knowledge gained by psychiatry in the future.

Nothing in the Act requires a showing at trial that persons found to be suffering from danger-productive mental illness will receive treatment while hospitalized. The section of the Act cited by Appellant as controlling has no language to this effect. Its legislative history contains no inkling that such a showing was ever considered by Congress. Nevertheless, there was a showing at trial in the testimony of the Saint Elizabeths staff psychiatrist that the hospital could offer a controlled environment including treatment, guidance, and therapy and that Mr. Alexander had apparently controlled his propensity for indecent exposure during earlier periods of hospitalization.

ARGUMENT

I. Mental deficiency may be considered as evidence of mental illness for purposes of commitment under the Act. The trial judge's jury instruction to this effect was not in error.

The clear intent of Congress was to allow mental defectives who are also mentally ill to be so found and hospitalized under the Act. Defectives were not to be included automatically as mentally ill. However, defectives were not to be excluded from coverage where they also had a danger-productive illness. Deficiency was seen as relevant to a determination whether the defective was also ill. As introduced, the language defining mental illness in the bill which became the law (S. 935 88th Cong., 1st Sess.) read:

> (1) the term "mental illness" means any psychosis or other disease which substantially impairs the mental health of an individual (but shall not include epilepsy, alcoholism, drug addiction, or mental deficiency);

109 Cong. Rec. 3114 (Daily Ed. Feb. 28, 1963).

At May 1963 hearings before the Subcommittee on Constitutional Rights of the Senate Committee on the Judiciary many of the organizations and individuals invited to testify dealt with this definition. A clear consensus emerged among them that the provision excluding mental defectives should be dropped to allow them to be hospitalized where they were also mentally ill. Speaking to this effect were Dr. Jack R. Ewalt, president of the American Psychiatric Association (*Hearings before the Subcommittee on Constitutional Rights of the Senate Committee on the Judiciary on a Bill to Protect the Constitutional Rights of the Mentally Ill*, 88th Cong., 1st Sess. 75 (1963) [hereinafter *1963 Hearings*], Dr. Sidney Berman for the Washington Psychiatric Society (*1963 Hearings* 77), Commissioner Duncan for the Commissioners Committee on Mental Health Needs (*1963 Hearings* 87), Dr. Dale Cameron, Superintendent of Saint Elizabeths (*1963 Hearings* 128), HEW (*1963 Hearings* 133), and Prof. Henry Weihofen, Director of the George Washington University Mental Competency Study (*1963 Hearings* 162, 178).

Dr. Berman stated that mental deficiency is a symptom which may be associated with various types of mental illness. Dr. Ewalt's statement also reflected this notion.

Chief Judge Bazelon had served as a member of the President's Panel on Mental Retardation [1] and, as chairman of the panel's task force on law, had drafted the report of the task force. His statement to the committee was the fullest one on points involved in this case. It pointed up both the advisability of dropping the exclusion of defectives from coverage and the relevance of a person's deficiency in determining whether he is also ill. In pertinent part Judge Bazelon said:

> My basic criticism of the bill lies in its failure to provide for the mentally retarded, and to the underlying assumption that mental illness is a disorder

[1] "Mental Retardation" seems to be used interchangeably with "Mental Deficiency" in psychiatric literature and is so used in this brief.

> which can always and necessarily be regarded as separable from mental retardation . . . . It is my understanding that bifurcated consideration of the two disorders is not medically justified. First, it seems, there are acute problems of diagnosis . . . sometimes it is exceedingly difficult to distinguish mental retardation from some forms of mental illness. Second, even where mental retardation is correctly diagnosed, psychological problems of differing degrees of intensity may also be present and require attention.
>
> To argue that the two conditions may be interrelated . . . is not to deny that, in practice, decisions frequently have to be made designating one condition or the other as primary. . . . The fact that the two handicapping conditions are less clearly separable than might at first appear does not mean, of course, that they can be regarded as synonymous.

1963 Hearings 208-209.

Congress responded to the witnesses' reasoning. Both the Senate and House reports accompanying the bill (S. 935) explained that:

> . . . This section differs from the original bill which had excluded epilepsy, alcoholism, drug addiction, or mental deficiency from the definition of mental illness. Witnesses testified that these symptoms often accompany mental illness and that persons who are mentally ill and have one or more of these conditions should not be excluded because of such a condition.

Senate Comm. on the Judiciary, *Protecting the Constitutional Rights of the Mentally Ill*, S. Rep. No. 925, 88th Cong., 2d Sess. 13 (1964) [hereinafter *Senate Report*] and House Comm. on the District of Columbia, *Protect the Constitutional Rights of Persons Who Are Mentally Ill*, H. Rep. No. 1833, 88th Cong., 2d Sess. 8 (1964) [hereinafter *House Report*].

The Congressional intent to allow involuntary hospitalization of defectives who also have a danger-productive illness is clear. The Congressional recognition of the rele-

vance of deficiency in determining whether such an illness exists is also clear.

That it is relevant is further pointed up in the following taken from the January, 1963 Report of the Task Force on Law of the President's Panel on Mental Retardation, chaired by Chief Judge Bazelon and Dr. Elizabeth M. Boggs, Research Chairman and Past President of the National Association for Retarded Children:

> *Mental Retardation and Other Disorders of Behavior*
>
> There is usually no essential relationship between mental retardation and other disorders of human behavior such as mental illness or delinquency. There are several factors, however, which can contribute to the incidence of behavioral disorders among the mentally retarded. The intellectually retarded person is predisposed to a life of failure in our highly competitive culture and, in compensation, may develop failure-avoidant patterns of behavior which could be categorized as emotionally disturbed. Sometimes, the retarded child may develop compensatory aggressive or withdrawal patterns as a result of being rejected by his peers or even members of his own family. Occasionally, the same factor which produced the damage to the nervous system causing retardation may also produce convulsive seizures, cerebral palsy, mental illness or other behavior disorders . . . .

For the law not to allow consideration of deficiency as evidence of possible illness would be inconsistent with the basic approach of psychiatry to the study of the individual and his behavior. Dr. Arthur P. Noyes, a leading psychiatrist, described this approach as follows:

> While other branches of medicine deal with parts of the organism, psychiatry or psychobiology studies the individual as a whole, as a biologic unit living in an environment that is essentially social in nature, and deals with the biophysic life, the total integrated behavior of the human organism. It deals with data from the biologic, social and psychological sciences.

Noyes, *Modern Clinical Psychiatry* 66 (4th ed., 1953), as quoted by Weihofen in *The Definition of Mental Illness*, 21 Ohio St. L.J. 5. Noyes and Kolb reflect this approach in stating in their basic textbook on psychiatry:

> Although disruptive to the individual's personal happiness and efficiency or disturbing to his social adjustment, it follows from what has been said that mental illness is the expression of a way of living. Even though it is in certain respects somewhat extreme, there is much truth in . . . [the] statement that the phenomenon of mental illness may be regarded as a type of participation in the social process rather than as an entity residing within a person.

Noyes and Kolb, *Modern Clinical Psychiatry* 92 (5th ed., 1958).

The trial judge's instruction was thus correct as consistent with the intent of Congress that defectives who are also dangerously ill be covered by the Act, consistent with the medical facts that deficiency and illness are sometimes closely related and sometimes related in a causative fashion, consistent with Congressional recognition that deficiency is a symptom which sometimes accompanies illness, and consistent with the basic approach of psychiatry in studying and classifying the behavior of individuals.

II. Commitment is justified under the Act by the existence in a mental defective of a danger-productive mental illness which is related to the mental deficiency and of which the deficiency may be one component. Proof of a coexisting mental illness independent of the deficiency is not required.

There is general agreement within both the legal and psychiatric disciplines that deficiency and illness are not synonymous. There is general agreement that defectives can also be ill and it is also undisputed that deficiency is sometimes a symptom of illness. In short, there is agreement that deficiency and illness, in both the legal and

psychiatric definitions, are neither synonymous nor always separable.

The Congressional intent was obviously to have the Act cover mental defectives who are also dangerously ill mentally. The testimony of a number of expert psychiatric and legal witnesses concurred, without contradiction by others, that deficiency is often associated with illness. The Washington Psychiatric Society statement was that mental deficiency is a symptom which may be associated with various types of mental illness. *1963 Hearings* 77.

Not one of the psychiatric or legal experts before the Senate and House committees testified that mental illness was always independent of mental deficiency and that proof of a recognized illness separate from the deficiency should be required as a necessary step in the involuntary hospitalization of dangerously ill persons who are deficient. There is nothing in the Act, and appellant has cited nothing claimed to have that effect, which requires proof of a coexisting mental illness independent of the mental deficiency to justify hospitalization of a defective who is ill. To find such a requirement where there is none would be in discord with both the weight of testimony before the Congressional committees and the present understanding by psychiatry of the relationship between deficiency and illness.

III. To meet the broad legal definition of mental illness in the Act, the illness which a person is found by a court or jury to have need not be precisely defined in psychiatric terms which describe one of the categories of illness currently recognized within the psychiatric discipline at its present stage of development.

A. The Act was enacted after careful consideration over a period of three years and was intended as a model for revision of state hospitalization laws. Senate Report 9-10. It defines mental illness broadly for its purposes as "a psychosis or other disease which substantially impairs the mental health of a person". The Act does not further define disease or mental health, nor does it

incorporate by reference the categories of mental illness recognized as such at the time of enactment by the American Psychiatric Association or by any other organization speaking for the psychiatric discipline.[2]

B. The Act's criterion for involuntary hospitalization of ill persons—a likelihood that the individual will injure himself or others if allowed to remain at liberty—is narrower than that found in most jurisdictions. Only a few states phrase the standard solely in terms of probability of harm. In some states a showing of need for care and treatment serves as an alternative or even exclusive basis for hospitalization. Some other states specify that hospitalization may be effected when the welfare of the individual so requires. Still others fails to state any criteria; presumably any person who meets the statutory definition of "mentally ill" or "insane" may be hospitalized.[3] From the standpoint of insuring that Mr. Alexander's Constitutional rights are protected, the Act's requirement that he be found to be dangerous leaves little reason for a further requirement that his illness be found to fall in one of the specific categories of illness currently recognized as such by psychiatry.

C. No cases in this jurisdiction have been found dealing with the question whether involuntary hospitalization of a defective under the Act must be preceded by a precise definition in psychiatric terms of the illness the defective has.

D. Experience in District of Columbia criminal law with an analogous question, while not directly applicable, is relevant. Prior to the decision in *Durham* v. *United States*, 94 U.S. App. D.C. 228, 214 F.2d 862 (1954) ac-

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[2] The official system of classification of the American Psychiatric Association published by it under the title, "Diagnostic and Statistical Manual of Mental Disorders" is given in Kolb and Noyes, *Modern Clinical Psychiatry* at 161-168 (5th Ed., 1958).

[3] Lindman & McIntyre, *The Mentally Disabled and the Law* 44-62 (1961) contains tables summarizing the statutory provisions of the then forty-eight states and the District of Columbia as of October 1959.

quittals based on insanity required a finding either that (a) the defendant did not understand that his act was a violation of the law or that (b) though possessed of this understanding, he was, nonetheless, impelled to do the act by an irrestible impulse. *Smith* v. *United States*, 59 U.S. App. D.C. 144, 36 F.2d 548 (1929). Citing the need to keep pace with psychiatric advances in an effort to insure that the mentally ill receive rehabilitative treatment, the court in *Durham* broadened the definition of "insanity", stating the rule simply that "an accused is not criminally responsible if his unlawful act was the product of a mental disease or mental defect". Beyond indicating that it meant disease to mean any condition considered capable of either improving or deteriorating and defect to mean any condition not considered capable or either improving or deteriorating, the *Durham* court did not further define these two terms, nor did it distinguish between a psychiatric definition of mental illness and a judicial definition. After eight years of experience with this very general formula, the court in *McDonald* v. *United States*, 114 U.S. App. D.C. 120, 312 F.2d 847 (1962) found it advisable to illuminate the *Durham* rule, to distinguish in doing so between the psychiatric and judicial definitions of mental disease and mental defect, and to articulate a judicial definition of mental disease and mental defect. It defined disease and defect as any abnormal condition of the mind which substantially affects mental or emotional processes and substantially impairs behavior controls. In adding substantial impairment of behavior controls as a necessary element in the definition, and in declaring that the jury would consider testimony concerning the development, adaptation, and functioning of these processes and controls, the *McDonald* court changed the standard of responsibility, in effect, from a two step finding of (1) mental disease or defect and (2) causal connection between the disease or defect and the unlawful act into a one step analysis. By this judicial standard a mental condition must have behavioral consequences to qualify as a mental disease. Thus the psychiatrists' terminology would no

longer control the question whether mental disease existed; the consequences of the mental condition would control it. "What the psychiatrists may consider a 'mental disease or defect' for clinical purposes, where their concern is treatment, may or may not be the same as mental disease or defect for the jury's purpose in determining criminal responsibility", the court said, adding that "the jury must determine for itself, from all the testimony, lay and expert, whether the nature and degree of the disability are sufficient to establish a mental disease or defect as we have now defined those terms." *McDonald* v. *United States*, 114 U.S. App. D.C. 120 at 124.

The court had previously pointed out in *Carter* v. *United States*, 102 U.S. App. D.C. 227 at 236, 252 F.2d 608 (1956) that to make a reasonable inference concerning the relationship between a disease and a certain act, the trier of facts must be informed with some particularity. This must be done by testimony. Unexplained medical labels—schizophrenia, paranoia, psychosis, neurosis, psychopathy—are not enough. Description and explanation of the origin, development and manifestations of the alleged disease are the chief functions of the expert witness. The chief value of an expert's testimony rests upon the material from which his opinion is fashioned and the reasoning by which he progresses from his material to his conclusion; in the explanation of the disease and its dynamics, that is, how it occurred, developed, and affected the mental and emotional processes of the defendant; it does not lie in his mere expression of conclusion.

After the *McDonald* decision the court continued to point out in criminal cases that the labels applied to particular diseases by psychiatrists within their own discipline were not critical for judicial purposes. When the government argued in *Hawkins* v. *United States*, 114 U.S. App. D.C. 44, 310 F.2d 849 (1962) that expert psychiatric testimony that defendant had a low grade mental disorder was insufficient to raise the question for the jury whether he had a mental disease or defect because the expert witness did not classify his mental condition as a disease, the

court called this a quibble and reaffirmed that whether the psychiatrist had classified it as a disease or not was not dispositive of the ultimate question. While the psychiatrist's opinion is admissible, it is not binding on the jury, since his diagnosis of a condition as a disease is not necessarily binding on the jury in the legal sense. This was a question for the jury. The court said that psychiatrists' opinions on ultimate questions reserved for the jury may not be particularly helpful. It reaffirmed that psychiatric testimony should be directed toward explaining what the expert has observed about the dynamics of the defendant's mental condition; for example, about his symptoms, his characteristics, behavior, and history; and toward indicating, if the psychiatrist is in a position to do so, the effect of the observed condition on the development, adaptation, and function of the defendant's mental or emotional processes and his behavior controls. This would provide the jury with a basis for deciding the ultimate question whether the defendant had a mental disease.

The court has continued to value the distinction established between the psychiatric and legal definitions of mental disease. In *Heard* v. *United States*, 121 U.S. App. D.C. 37, 348 F.2d 43 (1965) it noted the great effort that it had gone to since its holding in *McDonald* to restore the issue of criminal responsibility as one of fact for the jury and make it clear that the expert's label is relatively unimportant but that his description and explanation of the defendant's capacity to control behavior are critical. The court recalled that it had frequently urged that trial counsel and their expert witnesses should seek to avoid being content with mere expert conclusions and should emphasize the reasons, the factors, the symptoms, and the medical reasoning which led to the conclusions so that from the experts the jury will have a psychological profile of the accused and not simply a collection of psychiatric labels and jargon.

E. Making use in the civil commitment field of this experience built up in the criminal law field will mean rejecting appellant's demand that he not be hospitalized

unless the illness which the jury found he has has been labeled as a psychosis or other form of mental illness currently recognized within the psychiatric discipline as a disease entity independent of the mental retardation. It will mean that, while the law values a general judicial definition of mental illness as well as the psychiatric definition, the law will decline to give or require a merely semantic judicial characterization of Mr. Alexander's illness more precise than the characterization which the psychiatric discipline can presently give for it. In this regard, the law will have much in common with the expert psychiatrist witnesses at the trial. They were very clear that Mr. Alexander was ill and very clear in their description of his behavior reactions which led them to that conclusion, but they were reluctant to give a very precise verbal description in psychiatric terms of the type of illness he had. Making use of this experience will not mean, however, that the law will limit the extent to which it can take advantage of that knowledge which psychiatry can bring to bear. On the contrary, keeping the definition of mental illness within the Act deliberately broad will allow room for the future development of the psychiatric discipline. A loose fit at this union where the definitions given by the two disciplines meet will guard against a break as one or the other grows and will enhance the possibilities that the two will continue to cooperate in selecting those mentally disabled individuals, and only those disabled individuals, who should be involuntarily hospitalized.[4]

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[4] Providing such a looser and more durable fit between the judicial and psychiatric definitions of one type of mental illness, the psychopathic personality, was the course recommended by the British Royal Commission on the Law Relating to Mental Illness and Mental Deficiency: "In our opinion it would do much more harm than good to try to include in the law a definition of psychopathic personality on the analogy of the present legal definition of mental defectiveness. It is far preferable that, in referring to various forms of mental disorder, the law should use general terms which will convey a sufficiently clear meaning to the medical profession without trying to describe medical conditions in detail in semi-medical language. . . . It would in any case be particularly

difficult to find a suitable detailed description of psychopathic personality. Such a description would probably have to mention the particular aspects of the personality which may be affected, and possibly also try to give some guide as to the cause of the disorder. But there are too many different types of psychopathic personality, and too little is at present known about their essential nature and causes, for a description of this kind to be easily agreed; and even if one were agreed now, increasing knowledge might soon make it out of date. Lack of knowledge about the nature and causes of particular forms of disorder does not mean that they cannot be recognized and successfully treated in individual patients." Royal Commission on the Law Relating to Mental Illness and Mental Deficiency (1954-1957). Report Comnd. 169. H.M.S.O., (1957). Quoted in Morris, Comment, 21 Modern L. Rev. 63. This view favoring the looser fit between the definitions offered by the two disciplines is shared by Prof. Henry Weihofen, one of the witnesses before the Senate committee whose testimony resulted in dropping the exclusion from the bill's coverage of defectives who are also ill: "Mental illness is a medical concept, and so it would seem self evident that its definition should come from the medical profession and not from either legislators or judges. . . . Unfortunately the matter is not that simple. Turning to the medical profession to define 'mental illness' for us, we find no clear answer. A century ago, 'mental disease' was a fairly clear concept; all such disease was thought to be the product of lesions in the brain. Today, psychiatrists recognize that many mental disorders seem to be wholly functional; a post-mortem examination shows no organic pathology of any kind. So long as organic pathology was assumed to be involved, it was possible to regard the mentally ill as clearly distinct from those who were 'sane'. But since the recognition of functional disorders, and especially since Freud, the view that there is a clear, qualitative division between the sane and the mentally ill has largely been abandoned in favor of the quantitative view, that there is no such clear line between the two; there is rather an unbroken continuum from normal to abnormal. But if there is no longer black and white, but a continuous shading from one to the other, it becomes apparent that asking the medical expert where he draws the line between two shades of gray is not quite like asking him whether a bone is or is not fractured. . . . A few commitment laws undertake to define 'mental illness' or a 'mentally ill' person for the purpose of such laws, and these usually do so in terms of need for care and treatment. . . . It seems that any definition that is not too restrictive is likely to be too general to be very meaningful. . . . There seems to be little in the record to lead us to believe that any useful purpose would be served by departing from the policy that the law has, with very few exceptions, followed in the past, of leaving it to psychiatry to wrestle with the question of what does and does not come within the concept of 'mental illness', instead of attempting to lay down a legal definition." Weihofen, *The Definition of Mental Illness*, 21 Ohio St. L.J. 1-8 (Winter 1960).

IV. The trial court did not err in instructing the jury that a mental defect may be considered as a mental illness within the Act.

(Tr. 60-62, 69, 72, 76, 78-80)

There are no cases dealing with the question whether this was error. However, the judge's instruction on this point, taken in the context of his whole instruction, accurately reflected the language and policy of the Act. At no point did he charge that a mental defect *in itself* was equivalent to a mental illness. Rather he charged that mental illness meant any psychosis or other disease which substantially impairs the mental health of the individual and that for a person to be found mentally ill he must have an abnormal mental condition (Tr. 74). After a review of the *House Report's* statement that a provision excluding deficiency had been dropped expressly to allow hospitalization of defectives when ill (Tr. 60-61), appellant's counsel requested a jury instruction that "mental deficiency is a mental illness and if the jury so finds, they find he is suffering from a mental illness" (Tr. 62). Counsel also requested an instruction that the jury return a finding of fact whether there was "a mental deficiency or mental disease here" (Tr. 62).

Relying on the specific agreement of appellant's counsel to the instruction he now contests, appellee's counsel in his closing statement to the jury argued that Mr. Alexander was deficient and unable to control his behavior, that this exhibitionistic behavior made him dangerous in society, and that, "when you consider all of this, you will have little trouble in finding that he is mentally ill and likely to injure himself or others." (Tr. 69).

Following the closing statement of appellant's counsel, appellee's counsel further argued that, "you need not find that a person is suffering from a psychosis to find that he is mentally ill. In fact, there are other mental illnesses. One of them is mental deficiency, which the statute considers as a mental illness and an adequate ground for commitment." (Tr. 72).

After the judge's initial instruction, which did not include a specific charge as agreed upon that deficiency is an illness, appellee's counsel noted, "I thought your Honor had agreed to instruct that mental deficiency is a recognized mental illness. . ." (Tr. 78), and requested an instruction that, "mental deficiency is a mental illness under the Act." (Tr. 79). At that point appellant's counsel changed his position, withdrew from his earlier agreement to such an instruction, and indicated opposition to it (Tr. 79).

In this context the trial judge charged that the jury in this case might consider a mental defect as a mental disease within the meaning of the statute (Tr. 80) and coupled this directly with an instruction that the jury had also to find whether Mr. Alexander would be a danger to himself or others if not hospitalized and with the express caution that many mental defectives get along perfectly well in society (Tr. 80).

To argue as appellant does that it was error to instruct that mental deficiency, standing alone, is a mental illness is to attack an instruction that was never in fact given. To argue as appellant does that the difference between the two different mental conditions, deficiency as such and illness, was not drawn for the jury is to disregard what the trial court in fact said. To object now as appellant does to an instruction that the jury might consider a mental defect as a mental disease—an instruction which was given after appellant's counsel had requested an instruction that deficiency is an illness, which appellee's counsel relied on in his closing statement following the agreement of appellant's counsel thereto, and which was not objected to as given—provides no reason for questioning a verdict of mental illness abundantly supported by the evidence. Were this instruction error, it would have been harmless.

V. Commitment need not be preceded by a showing that a person found to be mentally ill will receive psychiatric treatment during hospitalization. Nevertheless, there was such a showing at trial.

(Tr. 30)

This comprehensive Act contains no provision requiring a pre-commitment showing that treatment will be received by persons found to be mentally ill. D.C. Code 21-562, 1961 Ed., (Supp. V 1966) cited by appellant as controlling, contains no language requiring such a showing and appellant cites none. The full text of the section reads:

> "Medical and psychiatric care and treatment; *records*
>
> A person hospitalized in a public hospital for a mental illness shall, during his hospitalization, be entitled to medical and psychiatric care and treatment. The administrator of each public hospital shall keep records detailing all medical and psychiatric care and treatment received by a person hospitalized for a mental illness and the records shall be made available, upon that person's written authorization, to his attorney or personal physician. The records shall be preserved by the administrator until the person has been discharged from the hospital." (Emphasis added.)

The *Senate Report* in commenting on the provision in the bill which became this section in the Act gives no indication that a required showing at trial was even considered by the framers. The comment is entirely confined to the records which are to be kept by the hospital. *Senate Report* 20. The Congressional intent is clear. It had nothing to do with a showing at trial.

The question whether a particular patient will receive the treatment to which he would be entitled after civil commitment was not properly before the court. Under the Act the only issues before the court were whether Mr. Alexander was mentally ill, and, if so, whether because of that illness he is likely to injure himself or others

if allowed to remain at liberty. D.C. Code 21-545 (b) (Supp. V 1966).

It is undisputed that one of the purposes of the Act is to guarantee that patients who are civilly committed under its provisions are thereafter afforded proper medical and psychiatric care and treatment. The framers of the Act carefully considered the argument that to hospitalize a person on the basis that he is in need of treatment and then not to afford him the requisite treatment is a violation of due process requirements of the Constitution which should entitle him to release on a writ of habeas corpus.[5] In commenting on this the *Senate Report* in a paragraph at 12 entitled, "Right to Treatment", noted that the courts have not yet vindicated this position, but that moral obligation to afford adequate treatment is not disputed. It noted that the bill would recognize this moral right by providing that patients hospitalized under court order be given a current examination of their mental condition by a physician at least once every six months. This, however, had nothing to do with D.C. Code 21-562, 1961 Ed., (Supp. V. 1966).

In any event, there was a showing that psychiatric treatment would be available at Saint Elizabeths. The staff psychiatrist from that hospital testified that the hospital could offer custodial care and a controlled environment, that this would include "treatment, guidance, and therapy, and I am sure there will be discussion with the patient around this problem for which he was returned to the hospital in the attempts (sic) to help him understand at whatever level we can that this [the indecent exposure] is something that is unacceptable." This staff

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[5] Appellant does not question his commitment on due process grounds, but merely asserts that D.C. Code 21-562, 1961 Ed., (Supp. V 1966) requires a showing at trial that he will receive treatment. A good statement of the desirability of a due process based "Right To Treatment" is in Birnbaum, Morton, M.D., *The Right to Treatment*, American Bar Association Journal XLVI (1960) 499. While advocating the recognition and enforcement of a legal right to treatment, Dr. Birnbaum admits that, "at present our law has not recognized this legal right although our society undoubtedly recognized a moral right to treatment". Birnbaum at 499.

psychiatrist also testified that the patient's objectionable behavior "apparently has not presented itself while he was in the hospital" (Tr. 30).

CONCLUSION

WHEREFORE, it is respectfully submitted that the judgment of the District Court should be affirmed.

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